TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MedMe Services Corporation

Respondent Name
Mitsui Sumitomo Insurance USA

MFDR Tracking Number
M4-16-3055-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 7, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Partial payment of $39.98 has been made for date of service 08-31-15. Procedure code A4595 was billed at 4 units; only 1 paid. We are requesting the amount of $39.98 be paid."

Amount in Dispute: $39.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 31, 2015	A4595	$39.98	$39.98

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation state fee schedule adj
   - 193 – Original payment decision maintained

- W3 – Appeal / reconsideration
- B13 – Payment for service may have been previously paid

Issues

1. Is an additional unit of service payable?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor states, "Procedure code A4595 was billed at 4 units; only 1 paid..." Review of the submitted medical claim finds in Line 24, (1), (G) - "4" as the number of units. Per the Explanation of benefits dated October 5, 2015, the following is listed as "additional information," "This code is reimbursed at 1 unit for a 2 lead stimulator and 2 units for a 4 lead stimulator." Based on the documentation submitted with this dispute, the Division finds a total of 2 units for code A4595 is allowed. The maximum allowable reimbursement will be calculated per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.203 (d) states,

> The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
>
> (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

Review of the Third Quarter Texas DMEPOS fee schedule finds: A4595 - $31.98. The maximum allowable reimbursement is calculated as follows: $31.98 x 125% = $39.98 x 2 = $79.96.

3. The total allowable for the service in dispute is $79.96. The carrier previously paid $39.98. The remaining balance due to the requestor is $39.98. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $39.98.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $39.98 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		July , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.